



MISSOURI ASSISTIVE TECHNOLOGY
TELECOMMUNICATION ACCESS PROGRAM FOR INTERNET (TAP-I)
APPLICATION FOR ADAPTIVE COMPUTER EQUIPMENT

In-state: 800/647-8557(v) 800/647-8558 (tty)
Out-of-state: 816/373-5193(v) 816/373-9315 (tty)
E-mail: matpmo@swbell.net

PART 1 – APPLICANT INFORMATION (PLEASE PRINT CLEARLY)

NAME (LAST, FIRST, MIDDLE INITIAL) _____

ADDRESS (If your mailing address is a P.O. Box, provide a street address for equipment delivery.) _____

CITY _____	STATE MO _____	ZIP CODE _____	COUNTY _____
HOME PHONE _____	WORK PHONE _____		
DATE OF BIRTH _____	SOCIAL SECURITY NUMBER _____		

The following are requirements for requesting adaptive computer equipment through the TAP-I program. If you cannot answer "yes" to all of the following, contact the TAP-I program to discuss a possible referral.

___ YES ___ NO I am a Missouri resident.

___ YES ___ NO My annual adjusted gross income is \$60,000 or less for each individual or individual and spouse. (Add \$5,000 for each additional dependent in the household.)

___ YES ___ NO I have Internet service. My Internet service provider is: _____
My e-mail address is: (Print clearly) _____

___ YES ___ NO I have a PC computer with: (Check one)
___ Windows 95 ___ Windows 98 ___ Windows ME
___ Windows XP (Home Edition) ___ Windows XP (Professional Edition)

___ YES ___ NO I have a Macintosh computer.

PART 2 – EQUIPMENT SELECTION

Upon the receipt of a completed and signed TAP-I Application form, you will be contacted to determine the adaptive computer equipment that should be ordered for you. To assist us in determining the level of support needed during the equipment selection process, please check all of the following that apply to you.

___ I have experience using a computer keyboard.

___ I have experience using a computer.

___ I do know the adaptive computer equipment I need for basic Internet access based on past experience and/or a trial period.

Please list: _____

___ I do not know what adaptive computer equipment I need for basic Internet access.

PART 3 – DISABILITY CERTIFICATION

(To be completed by a licensed physician, speech pathologist, audiologist, hearing instrument specialist or a Missouri Assistive Technology approved consumer support provider.)

I hereby certify that _____ is unable to use traditional computer equipment for Internet access due to the disability indicated below.

☐ Low Vision ☐ Blind ☐ Vision and Hearing
☐ Reading decoding and/or comprehension disability - Briefly describe:
☐ Physical disability - Briefly describe:
☐ Other disability - Briefly describe:

Please check the appropriate certification category below:

☐ Physician ☐ Speech Pathologist ☐ Audiologist ☐ Hearing Instrument Specialist
☐ State License Number: _____

☐ Missouri Assistive Technology Approved Consumer Support Provider

Date: _____

Certifying Authority Signature: _____

Certifying Authority Printed Name: _____

Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: _____ E-Mail: _____

PART 4 – APPLICANT SIGNATURE AND INFORMATION RELEASE

The above facts are true and complete to the best of my knowledge. Upon request, I will provide verification of the information provided. I authorize TAP for Internet to release my name, address, and phone number to a consumer support provider.

Applicant or Guardian Signature

Date

(Original signature required. Do not fax application.)

Mail completed and signed application to:
TAP for Internet, 4731 South Cochise, Suite 114
Independence, MO 64055-6975

(1/2006)